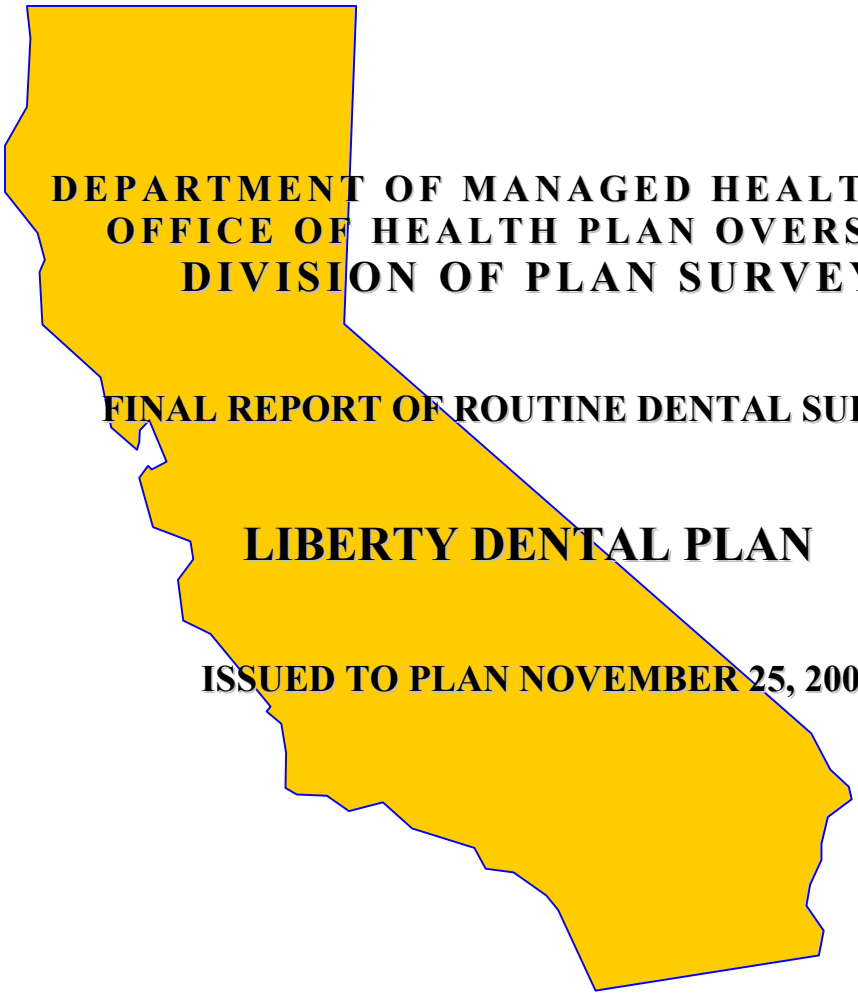
STATE OF CALIFORNIA



DEPARTMENT OF MANAGED HEALTH CARE
OFFICE OF HEALTH PLAN OVERSIGHT
DIVISION OF PLAN SURVEYS

FINAL REPORT OF ROUTINE DENTAL SURVEY

LIBERTY DENTAL PLAN

ISSUED TO PLAN NOVEMBER 25, 2002

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I. Introduction

The Knox-Keene Health Care Service Plan Act of 1975 (the "Act"), Section 1380, requires the Department of Managed Health Care (the "Department") to conduct a dental survey of each licensed health care service plan ("Plan") at least once every three (3) years. The dental survey is a comprehensive evaluation of the Plan's compliance with the Knox-Keene Act. The subjects covered in the survey are listed in Health and Safety Code Section 1380 and in Title 28 of the California Code of Regulations, Section 1300.80.[1] Generally, the subjects of the survey fall into the following categories:

- Quality Assurance Program
- Accessibility of Services
- Utilization Management
- Grievance System

This Preliminary Report summarizes the findings of the dental survey of Liberty Dental Plan, Inc. (the "Plan"). The Plan submitted pre-survey documentary information to the Department on June 7, 2002. The Department conducted the on-site survey of the Plan on July 10-12, 2002 and the exit conference was conducted on July 12, 2002.

Follow-up Action Required By The Plan

This Preliminary Report provides an overview of the survey findings and serves as notice to the Plan of the deficiencies found by the survey team. In accordance with Section 1380(h)(2), the Plan has forty-five (45) calendar days from the date of receipt of this report to file a written response to the Preliminary Report. The Preliminary Report focuses on deficiencies found during the dental survey. Only specific areas found by the Department to be in need of improvement are included in the report. Omission of other areas of the Plan's performance from the report does not necessarily mean that the Plan is in compliance with the Knox-Keene Act. The Department may not have surveyed these other areas or may not have obtained sufficient information to form a conclusion about the Plan's performance.

All deficiencies cited in the preliminary report require follow-up action by the Plan. The Department has specified Corrective Actions in cases where factual findings of a deficiency constitute a violation of the Knox-Keene Act. The Plan must implement all required actions in the manner prescribed by the Department. The Plan must submit evidence that the required actions have been or are being implemented when the Plan submits its 45-day response.

[1] References throughout this report to "Section ____" are to sections of the Knox-Keene Health Care Service Plan Act of 1975, as Amended ("the Act"), codified at Health and Safety Code Section 1340 *et seq*. References to "Rule ____" are to the regulations promulgated pursuant to the Act, found at subchapter 5.5 of Chapter 3 of Title 28 of the California Code of Regulations, beginning at Section 1300.43 and transferred to the Department of Managed Health Care pursuant to Section 1341.14.

The Plan's response should include the following information for each deficiency identified in the Preliminary Report:

1. The Plan's response to the Department's findings of deficiency;

2. The Plan's response to the Department's Required Actions;

3. Whether the corrective action will be fully implemented by the time the Plan submits its response. If the corrective action is fully implemented, the Plan should provide documents or other evidence that demonstrate the deficiency has been corrected.

4. If the corrective action cannot be fully implemented by the time the Plan submits its response, the Plan should submit evidence that the corrective action has been initiated and is on the way to achieving compliance. Please include a time-schedule for implementing the corrective action and a full description of the evidence the Plan will submit for the Department's follow-up review that will show the deficiency has been fully corrected.

If the Plan wishes to organize its response into a chart or table format, it may do so. Documents submitted in connection with the response should be attached as Exhibits. If the Plan submits its response in tabular form, the Department requests that the Plan include a detailed narrative of each response sufficient to fully inform the Department of the plan's position regarding the deficiency and plan of corrective action. The narrative and tabular response should identify and reference each of the documents by title and exhibit number.

The Plan may request that designated portions of the response be maintained as confidential, pursuant to Section 1380(g)(6). The Plan should file any policies and procedures required for implementation as plan amendments and/or material modifications pursuant to Section 1352 and Rule 1300.52.4 with DMHC Legal Counsel after the Department reviews the Plan's response to the Preliminary Report. The Plan should file both a clean and redline version of revised policies and procedures.
Upon review of the Plan's response to the Preliminary Report the Department will publish a Final Report, which will first be issued to the Plan followed by the public file. In any event, the Final Report will be issued to the public file not more than 180 days from the conclusion of the on-site survey. The Department will also issue a Summary of the Final Report to the public file at the same time it makes the Final Report available to the public. The Plan may submit additional responses to the Final Report and the Summary Report at any time before or after they are issued to the file.

The Department has also included Section V, (Additional Findings and Recommendations), in the report to provide the Plan feedback on areas of the operations that were observed by the survey team during the on-site review, but are not specifically defined by the regulatory guidelines as stated in the Knox-Keene Act (the "Act"). The Plan is encouraged to review these findings and recommendations as they may indicate systemic issues that could cause the Plan to be out of compliance with the Act during future surveys.

The Department will conduct a Follow-up Review of the Plan within 18 months of the date of the Final Report to determine whether the uncorrected deficiencies identified by the Department have been corrected. See Health and Safety Code section 1380(i)(2). Please note that the Plan's failure to correct deficiencies identified in the survey report may be grounds for disciplinary action against the plan as provided by Health & Safety Code section 1380(i)(1).

Scope of Survey

The Department reviewed the Plan's pre-survey documents that the Plan submitted on June 7, 2002, in response to the Department's survey notification letter. The pre-survey material included information regarding the Plan's former history, December 2001 acquisition of Plan by Liberty Dental Plan, new organization structure, quality assurance and utilization management program, access and availability, and grievance system.

During the onsite conducted on July 10 –12, 2002, at the Plan's administrative offices, the Department reviewed documents that pertained to utilization management, access and availability, grievances and quality assurance. But because the Plan had been operational only 6 months at the time of the survey, it had not received any grievances or appeals, nor had it collected utilization data or conducted provider audits for the Department to review. Thus, the scope of the survey was limited to reviewing only the Plan's written policies and procedures. The Department also conducted interviews with staff responsible for these areas. A complete interview list is presented in Appendix A.

The Department will review those areas not able to be reviewed during the routine survey during the follow up review.

History and Organization Structure

Liberty Dental Plan is a specialized health care service plan providing dental care services on a capitated basis to general dentists and on a fee-for-service basis to specialist dentists. Liberty Dental Plan is a California S-corporation with two shareholders.

The Plan originally became a licensed specialized health care service plan under the Knox-Keene Act in 1978 as Personal Dental Services. Later the Plan operated under a new name, Preferred Dental Plan. Liberty Dental Plan purchased the Knox-Keene license and the book of business from Preferred Dental Plan (Preferred Health Plan, Inc.) on December 27, 2001. The Plan is currently licensed in seventeen (17) counties.

The Plan operates as a network HMO contracting directly with independent dental practices. The Plan does not delegate any services to other entities.

The Plan has approximately 4,000 members to date. Although the Plan's policies and procedures appear to be appropriate, the Plan has not had the opportunity to fully implement their processes due to the recent acquisition and reorganization. As of the onsite date, the Plan had not received any formal grievances, appeals, or conducted any provider audits. The Plan is in the process of implementing an information system (IS) so it can review utilization data and trending.

II. OVERVIEW OF ORGANIZATION

The following additional background information describes the Plan:

Date Plan Licensed	The Plan was originally licensed in 1978 as Personal Dental Services. Later known as Preferred Dental Plan. In 2001, a material modification was submitted to the Department for a of change ownership. The Department approved the material modification on December 13, 2002. The Plan is now licensed as Liberty Dental Plan of California, Inc..
Type of Plan	Specialized health care service plan
Provider Network	The Plan contracts with independent general dentist and specialty dentists to provide dental care throughout California. As of July 2002 there are **860 General Dentists and 288 Specialty Dentists.** See Table 1, page 10.
Provider Compensation	All general dentist offices are capitated with Liberty Dental Plan paying a fixed fee. The Plan processes all regular and emergency specialty referrals. All specialists are reimbursed on a pre-negotiated fee-for-service basis.
Plan Enrollment	As of June 30, 2002, total California enrollment was **4,079**. Their products line is commercial only. Members select a primary care dentist (PCD) who is responsible for coordinating all dental care services including specialty care referrals, emergency dental care and routine dental care. PCDs contract directly with Liberty

	Dental Plan. The Plan reimburses all general dentists on a capitation basis and all specialty dentists on a fee-for-service basis.
Specialty Referral Network	The general dentist's office initiates specialty referrals. The Plan reviews the requested services and communicates the referral through preauthorizations. The rendered services are compensated on a pre-negotiated fee-for-service basis. Emergency specialty referrals are processed within 24 hours. Prior authorizations are not required, although the Plan recommends pre-authorization to communicate benefits to its members and providers.
Quality Management and Improvement Program	The Plan states that their QA program is designed to objectively and systematically monitor and evaluate the quality, appropriateness and outcome of care and services. The Plan's Quality Management and Improvement Program is directed by its Chief Dental Officer and includes the following committees: • Public Policy Committee • Quality Assurance Committee • Grievance Committee • Utilization Management Committee • Peer Review Committee The Quality Assurance Committee develops, reviews, and approves all aspects of dental care provided by Liberty Dental Plan provider network including the structure of care, the process and outcome of care, utilization and access to care, availability, continuity of care, safety, appropriateness, and any problem resolution in the dental delivery system identified by the Peer Review, Utilization Management or Grievance Committee. The Credentialing Subcommittee is responsible for reviewing, accepting, or rejecting the professional credentials of each applicant dentist and contracted dental provider. The Utilization Management Committee is designed to coordinate all utilization activities of the Plan and review plan member encounter data that is collected from Participating Provider offices. The Committee aims to identify abnormal utilization patterns and to report them to the Chief Dental Officer and Quality Assurance Committee. The Grievance Committee reviews, investigates, and responds to all member/provider disputes related to the Plan, a provider, or member. The Committee also monitors patterns of disputes and makes recommendations to the Quality Assurance Committee regarding a provider, member or group. The Peer Review Committee reviews case specific matters including individual credentialing decisions, clinical grievances, quality-of-care issues and provider corrective action plans. The Public Policy Committee is a forum that discusses industry practices. The Committee meets quarterly to review all plan activities and issues

	related to the improvement of plan design and service. Topics of discussion may include grievances, administrative grievance appeals, marketing activity, operational policies, plan and benefit questions and clinical procedures.
Utilization Management Program	The scope of the UM program includes all activities that have a direct or indirect influence on appropriate utilization of dental services delivered to Plan enrollees. The Chief Dental Officer holds an unrestricted license to practice dentistry in California and is responsible for the following major committees: • Public Policy Committee • Quality Assurance Committee • Grievance Committee • Utilization Management Committee • Peer Review Committee Policies and procedures are developed by the Chief Dental Officer and QA committee and are designed to be consistent with professionally recognized standards of care. Only licensed dentists authorize, modify or deny claims and resolve quality related grievances. The Plan is in the transition of implementing an IS System that allows for data gathering and utilization reviews which will aid in preparing reports that are reviewed and analyzed by the Chief Dental Officer and the QA committees.
Access Standards	The Plan monitors its performance against the standards set by its QA Committee. The results are discussed at the QA Committee, which are held quarterly (or more frequently if necessary). The objective of the Plan availability and access policies and procedures are to: 1. identify guidelines for scheduling routine, urgent, and emergency appointments, 2. identify guidelines for services after hours, and 3. establish guidelines consistent with recognized standards of care. The Plan policies and procedures outline how to evaluate and trend appointment availability and time to determine if the Plan providers meet or exceed access and appointment standards as defined in the policy. The Plan states that at least ninety percent (90%) of enrollees have access to one contracted general dentist within 15 miles and to one specialty dentist within 25 miles.

Grievance System	The Plan's Grievance Committee and the Chief Dental Officer have the overall responsibility for the grievance system. The Plan has designated grievance analysts who have the day-to-day responsibility of ensuring the grievances are handled appropriately and in a timely manner. The Plan has a written description of its system for receipt, handling and resolution of complaints and grievances. The system includes documentation of the grievance, investigation, actions taken, and enrollee notification by the Plan as well as use of appropriate level staff for review and resolution of grievances. Members can communicate a grievance via mail, fax, telephone, in-person, or by e-mail to Liberty Dental Plan. The Grievance/Complaint forms can be obtained from Liberty Dental Plan's Member Service department or at a contracting provider office. Plan employs a three level appeals process, which is communicated to the members via the grievance and appeals response letters. A different dentist member of the Peer Review Committee reviews the first appeal. A dentist consultant other than the first two reviewing dentists will handle the second appeal. The Chief Dental Officer will perform a third level quality of care review for all the issues involving quality of care. If the Chief Dental Officer doesn't reverse the Plan's previous determination, the member's appeal may be referred to the executive sub review committee. Additionally, members are notified of their appeals rights in all EOCs and grievance determination letters. DMHC's contact information is included in EOCs and any grievance correspondence. If an urgent or expedited intervention is deemed necessary by the Plan, then the member is notified in writing of the Plan's procedure for handling expedited grievances and appeals.

Table 1-Provider Network

TYPE OF PROVIDERS	NUMBER IN NETWORK
General	860
Endodontics	29
Pedodontics	21
Oral Surgery	79
Periodontics	58
Orthodontics	100

Table 2-Plan Enrollment per County.

	COUNTY	Enrollment	COUNTY	Enrollment	COUNTY	Enrollment
Current Service Area and Enrollment by County	**Alameda**	10	**Riverside**	66	**San Mateo**	6
	Contra Costa	5	**Sacto.**	10	**Santa Barbara**	1
	Fresno	1	**San Bernardino**	59	**Santa Clara**	12
	Kern	7	**San Diego**	1,298	**Solano**	12
	Los Angeles	400	**San Francisco**	9	**Ventura**	5
	Orange	95	**San Joaquin**	0		

Table 3-Access Standards

Type of Service	Standard
Emergency Appointments	24 hours
Routine Exam Appointments	2-4 weeks
Prophylaxis Appointments	2-4 weeks
Routine Dental Treatment	2-4 weeks

III. SUMMARY OF DEFICIENCIES IDENTIFIED IN DENTAL SURVEY

QUALITY ASSURANCE PROGRAM

Deficiency 1: The Plan's governing body did not demonstrate adequate oversight of the QA Program activities, and responsibilities for enrollees covered under their Plan. The Plan has not demonstrated that dental decisions are not influenced by fiscal and administrative management, nor that it has an adequate number of administrative and clinical staff to develop, implement, and evaluate quality improvement activities. **[Rule 1300.70(b)(2)(B) and (C), 1300.67(a)(1)(2) and (3)**

Deficiency 2: The Plan's process for reviewing the quality of care and performance of dental personnel has not demonstrated that quality of care issues are being reviewed, problems are being identified, and effective action is being taken and followed-up to correct the deficiencies. In addition, there is no evidence that the Plan reports QA program findings and follow-up activities to the governing body. **[Rule 1300.70(a)(1) and (3); Rule 1300.70(b)(1)(A) (B) and (C)]**

Deficiency 3: The Plan has not demonstrated that it has dental preventive care guidelines that should be used by its providers to educate it enrollees regarding preventive care. **[Rule 1300.70(b)(G)(5) and (6)]:**

UTILIZATION MANAGEMENT

Deficiency 4: The Plan's UM program does not describe the oversight of the UM process by the dental director. **[Section 1367.01(c)]**

Deficiency 5: The Plan does not have adequate written policies and procedures establishing the process and timeframes by which the Plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees in regards to dental services. The Plan also has not demonstrated that the UM Program had been reviewed and approved by the governing board. **[Section 1367.01(b) and (f);Section 1363(b)]**

IV. DISCUSSION OF DEFICIENCIES AND CORRECTIVE ACTIONS

The Department of Managed Health Care survey of Liberty Dental Plan (the "Plan") has found the following deficiencies, which the Plan is required to correct:

QUALITY ASSURANCE PROGRAM

Deficiency 1: The Plan's governing body did not demonstrate adequate oversight of the QA program, activities, and responsibilities for enrollees covered under the Plan. The Plan has not demonstrated that dental decisions are not influenced by fiscal and administrative management, nor that it has an adequate number of administrative and clinical staff to develop, implement, and evaluate quality improvement activities. **[Rule 1300.70(b)(2)(B) and (C), 1300.67(a)(1)(2) and (3)**

Citation: Rule 1300.70(b)(2)(B)
Written documentation shall delineate QA authority, function and responsibility, and provide evidence that the plan has established quality assurance activities and that the plan's governing body has approved the QA Program. To the extent that a plan's QA responsibilities are delegated within the plan or to a contracting provider, the plan documents shall provide evidence of an oversight mechanism for ensuring that delegated QA functions are adequately performed.

Citation: Rule 1300.70(b)(2)(C)
The Plan's governing body, its QA committee, if any, and any internal or contracting providers to whom QA responsibilities have been delegated, shall each meet on a quarterly basis, or more frequently if problems have been identified, to oversee their respective QA program responsibilities. Any delegated entity must maintain records of its QA activities and actions, and report to the plan on an appropriate basis and to the plan's governing body on a regularly scheduled basis, at least quarterly, which reports shall include findings and actions taken as a result of the QA program. The Plan is responsible for establishing a program to monitor and evaluate the care provided by each contracting provider group to ensure that the care provided meets professionally recognized standards of practice. Reports to the Plan's governing body shall be sufficiently detailed to include findings and actions taken as a result of the QA program and to identify those internal or contracting provider components, which the QA program has identified as presenting significant or chronic quality of care issues.

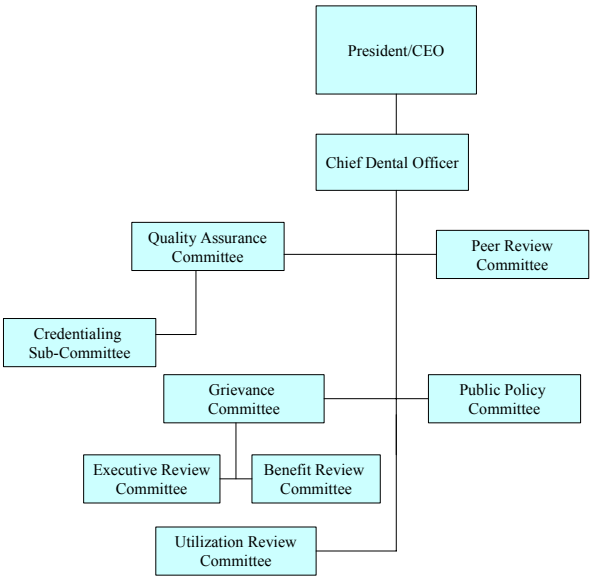
Citation: Rule 1300.67.3(a)(1)(2)(3)
The organization of each plan shall provide the capability to furnish in a reasonable and efficient manner the health care services for which subscribers and enrollees have contracted. Such organization shall include:

1. separation of medical services from fiscal and administrative management sufficient to assure the Director that medical decisions will not unduly influenced by fiscal and administrative management,
2. staffing in medical and other health services, and in fiscal and administrative services sufficient to result in the effective conduct of the plan's business, and,
3. written procedures for the conduct of the business of the plan, including the provision of health care services, so as to provide effective controls.

Discussion:

The Department's review of the Plan's organizational structure (see below) identified that the Plan has not established a Board of Directors. The Plan documents discuss that all committees report to the Chief Dental Officer and the Plan's President/CEO, who is the owner of the Plan. Both the Chief Dental Officer and the President/CEO have the authority on behalf of Liberty Dental Plan to resolve urgent grievances and authorize the provision of health care services covered under the member's plan contract. The authority also includes the ability to make financial decisions on behalf of Liberty

Dental Plan, which indicates that the Plan does not demonstrate that there is adequate separation of dental decisions from fiscal matters. The Department did not find that the Plan's President's duel responsibilities as CEO and owner of the Plan created problems with making dental decisions. The President explained that because the Plan has operated under the new ownership for only six months, it was still assembling a board of directors, which would be in place within a few months. In the interim, the Chief Dental Officer and committees would report to him.



Corrective Action:

The Plan shall submit a corrective action that demonstrates the separation of dental services from fiscal and administrative management sufficient to assure the Department that dental decisions will not be unduly influenced by fiscal and administrative management. In addition, the Plan shall submit documentation that there is a governing board and that the governing board has formally adopted and approved the Plan's QA Program.

***Plan's Compliance Effort*:**

The Plan stated their organizational chart lacked proper oversight by the Board of Directors because the Plan had operated only six months prior to the date of the survey. During that time all relevant responsibilities (committee activities, resolution of urgent grievances, and authorization for provision of health care services) were handled by the Plan's President/CEO.

The Plan stated that it was in the process of assembling a Board of Directors. The first meeting occurred on October 11, 2002. All responsibilities previously held by the Plan's President/CEO have been transferred to the newly assembled Board of Directors. The Plan submitted a Work Plan for the fourth quarter 2002, calendar year 2003 and a updated organizational chart which includes a Board of Directors as part of their corrective action.

Department's Finding Concerning Plan's compliance Effort:

Status: Uncorrected

Department's Comment:

The Plan has taken steps to remedy the deficiency as requested. However, the Plan was unable to demonstrate full compliance within the 45 day response. The Department's review of the Plan's corrective action indicates that the Plan has initiated a process/mechanism for the separation of dental services from fiscal and administrative management and that a Board of Directors has been assembled and in place to oversee the Plan's dental operations. At the time of the Follow-Up Review, the Department will evaluate the current status of the corrective action plan.

Deficiency 2: The Plan's process for reviewing the quality of care and performance of dental personnel has not demonstrated that quality of care issues are being reviewed, problems are being identified, and effective action is being taken and followed up to correct the deficiencies. In addition, there is no evidence that the Plan reports QA program findings and follow-up activities to the governing body.
[Rule 1300.70(a)(1) and (3); Rule 1300.70(b)(1)(A) (B) and (C)]

Citation: Rule 1300.70(a)(1) and (3)
(1) The QA program must be directed by providers and must document that the quality of care provided is being reviewed, that problems are being identified, that effective action is taken to improve care where deficiencies are identified, and that follow-up is planned where indicated.
(3) A plan's QA program must address service elements, including accessibility, availability, and continuity of care. A plan's QA program must also whether the provision and utilization of services meet professionally recognized of practice.

Citation: Rule 1300.70(b)(2)(A)
Each plan's QA program shall meet all of the following requirements:
(A) There must be a written QA plan describing the goals and objectives of the program and organization arrangements, including staffing, the methodology for on-going monitoring and evaluation of health services, the scope of the program, and required levels of activity.

Citation: Rule 1300.70(b)(2)(B)
Written documentation shall delineate QA authority, function and responsibility, and provide evidence that the plan has established quality assurance activities and that the plan's governing body has approved the QA Program. To the extent that a plan's QA responsibilities are delegated within the plan or to a contracting provider, the plan documents shall provide evidence of an oversight mechanism for ensuring that delegated QA functions are adequately performed.

Citation: Rule 1300.70(b)(2)(C)
The Plan's governing body, its QA committee, if any, and any internal or contracting providers to whom QA responsibilities have been delegated, shall each meet on a quarterly basis, or more frequently if problems have been identified, to oversee their respective QA program responsibilities. Any delegated entity must maintain records of its QA activities and actions, and report to the plan on an appropriate basis and to the plan's governing body on a regularly scheduled basis, at least quarterly, which reports shall include findings and actions taken as a result of the QA program. The Plan is responsible for establishing a program to monitor and evaluate the care provided by each contracting provider group to ensure that the care provided meets professionally recognized standards of practice. Reports to the Plan's governing body shall be sufficiently detailed to include findings and actions taken as a result of the QA program and to identify those internal or contracting provider components, which the QA program has identified as presenting significant or chronic quality of care issues.

Discussion:

At the time of the onsite, the Plan could not provide any data to establish that it collects information to monitor, review, and evaluate the quality of enrollee care to ensure that its dental services meet professionally recognized standards of practice to assist them in their analysis. Although the Plan informs the Department that it is in the process of installing an IS to assist in the collection and analysis of QA Program data, the IS installation will take up to six months to complete.

In addition, the Plan has policies and procedures in place for reviewing and correcting quality of care concerns. One mechanism would rely on conducting provider audits, but the Plan has not implemented its process to measure quality of care and performance of the Plan's provider network to ensure that problems are identified and effective action will being taken.

Corrective Action:

The Plan shall submit a corrective action demonstrating implementation the Plan's policies and procedures to ensure that quality of care is being reviewed, problems are being identified, effective action is being taken to improve care where deficiencies are identified, and that follow-up is planned where indicated. The Plan must also demonstrate that policies are formally adopted, approved by the appropriate body, and implemented by the Plan.

Plan's Compliance Effort:

To date, the first phase of the IS installation has been completed with initial reporting of patient encounter data taking place and is anticipated to be finalized by the end of October 2002. The Plan stated in their response that they are in final stages of installing an IS system to assist in the collection and analysis of QA program data. This includes administrative functions involved with evaluating the delivery of care with the Plan's panel of network providers.

The Plan submitted as part of their CAP a Work Plan for the last quarter of 2002. The Plan states in their Work Plan they have a processes to monitor, review, and evaluate quality of care. The Work Plan for calendar year 2003 documents how quality of care issues will be reviewed, problems identified, and effective action is being taken and followed up. In addition, with the initial phase of the Utilization Management reporting mechanism having been completed, the Plan's Quality Improvement Program findings and follow-up activities are scheduled to be reported to the governing body, starting with the Quality Assurance meeting that was scheduled on October 11, 2002. The Quality Assurance Committee will be reviewing the draft policies and procedures for monitoring, review, and evaluation of quality of care of Plan enrollees.

The Plan also submitted as an exhibit a Quality Assurance Work Plan. The Plan states it will provide documentation detailing the activities as a result of Quality Assurance Work Plan 2003/2003 at the Department's follow up review.

Department's Finding Concerning Plan's Compliance Effort:

Status: Uncorrected

Department's Comment:

The Plan has taken steps to remedy the deficiency as requested. However, the Plan was unable to demonstrate full compliance within the 45 day response. The Department's review of the Plan's corrective action indicates that the Plan has initiated a process/mechanism for monitoring, identifying problems, and effective action is being taken and followed up. At the time of the Follow-Up Review, the Department will evaluate the current status of the corrected deficiency.

Deficiency 3: The Plan has not demonstrated that it has dental preventive care guidelines on how to promote effective communication and awareness between members and providers. **[Rule 1300.70(b)(G)(5) and (6)]:**

Citation: Rule 1300.70(b)(G)(5)
Ensure that for each provider the quality assurance/utilization review mechanism will encompass provider referral and specialist care patterns of practice, including an assessment of timely access to specialists, ancillary support services, and appropriate preventive health services based on reasonable standards established by the plan and/or delegated providers.

Citation: Rule 1300.70(b)(G)(6)
Ensure that health services include appropriate preventive health care measures consistent with professionally recognized standards of practice. There should be screening for conditions when professionally recognized standards of practice indicate that screening should be done.

Discussion:

The Department's review of the QM program identified that the Plan has not developed preventive care guidelines. In addition, there are no guidelines for caries prevention, periodontal disease, and educational efforts. The Plan did send out a selection of oral health educational materials that was distributed on June 1, 2002 to their employer groups and enrollees.

Corrective Action:

The Plan shall demonstrate that it has preventive care guidelines that adequately ensure its dental services include appropriate preventive health care measures consistent with professionally recognized standards of practice. The guidelines should also describe how the Plan can effectively communicate these guidelines to provider and enrollees.

Plan's Compliance Effort:

The Plan states that they are developing dental preventive care guidelines and dental educational materials to send out to its employer groups and subscribers, individual members, and participating providers. The Plan submitted as part of their corrective action, a copy of a draft newsletter that will be sent out the first quarter of 2003.

Department's Finding Concerning Plan's compliance Effort:

Status: Uncorrected

Department's Comment: *The Plan has taken steps to remedy the deficiency as requested. However, the plan was unable to demonstrate full compliance within the 45 day response. The Department's review of the Plan's corrective action indicates that the Plan has initiated a process/mechanism for developing preventive care guidelines, dental educational materials, and newsletters to effectively communicate the information to their members and providers. At the time of the Follow-Up Review, the Department will evaluate the current status of the corrected deficiency.*

UTILIZATION MANAGEMENT

Deficiency 4 The Plan's UM program does not describe the oversight of the UM process by the dental director. **[Section 1367.01(c)]**

Citation: Section 1367.01(c)
Every health care service plan subject to Section 1367.01, shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued to pursuant Section 2050 of the Business and Professional Code or pursuant to Osteopathic Act, or if the plan is a specialized health care services plan, a clinical director with a California licensure in a clinical area appropriate to the type of care provided by the specialized health care service plan. The medical director or clinical director shall ensure that the process by which the plan reviews and approves, modifies, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, complies with the requirements of this section.

Discussion:

The Plan's UM program identifies that the Chief Dental Officer is responsible for UM program. However, the UM program does not describe the function of the Chief Dental Officer's role and responsibilities in regards to oversight i.e., following up to ensure that all UM functions are functioning according to protocol, collecting data/information, report to the President/CEO and Board of Directors.

Corrective Action:

The plan shall submit a corrective action that provides a description of the Chief Dental Officer's role and function as it relates to the UM program.

Plan's Compliance Effort:

The Plan submitted a copy of their policies and procedures for "Utilization Review Data/Report" which describes utilization data collection and how the information is reported and analyzed by the Utilization Review Committee, UR Coordinator and Dental Director.

Department's Finding Concerning Plan's compliance Effort:

Status: Uncorrected

Department's Comment:

The Plan has taken steps to remedy the deficiency as requested. However, the Plan was unable to demonstrate full compliance within the 45 day response. The Department's review of the Plan's corrective action indicates that the Plan has initiated a process/mechanism for the oversight of the Utilization Management process by the Chief Dental Officer and Dental Director. At the time of the Follow-Up Review, the Department will evaluate the current status of the corrected deficiency.

Deficiency 5: The Plan does not have adequate written policies and procedures establishing the process, and timeframes by which the Plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies,

based in whole or in part on medical necessity, request by providers of health care services for plan enrollees. The Plan also has not demonstrated that the UM Program had been reviewed and approved by the governing board.
[Section 1367.01(b) and (f);Section 1363(b)]

Citation: Section 1367.01(b)
A health care service plan that is subject to this section shall have written policies and procedures establishing the process by which the plan prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for plan enrollees. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. These criteria and guidelines shall be developed pursuant to Section 1363.5. These policies and procedures, and description of the process by which the plan reviews and approves, modifies, delays, or denies request by providers prior to, retrospectively, or concurrent with the provision of health care services to enrollees, shall be filed with the director for review and approval, and shall be disclosed by the plan to providers and enrollees upon request, and by the plan to the public upon request.

Citation: Section 1367.01(f)
The criteria or guidelines used by the health care service plan to determine whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with, the provision of health care services to enrollees shall be consistent with clinical principles and processes.

Citation: Section 1363.5(b)
The criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify or deny health care services shall:
(1) Be developed with involvement from actively practicing health care providers
(2) Be consistent with sound clinical principles and processes
(3) Be evaluated, and updated if necessary, at least annually

Discussion:

The Plan has not demonstrated it has adequate written policy and procedures for reviewing routine referrals or for approving, modifying, or denying requests by providers prior to, or concurrent with, the provision of health care services to enrollees, within five business days after the Plan's receipt of the information reasonably necessary to make the determination. The Plan's policy consisted only of a brief summary and a table with timeframes, and failed to give a sufficient description of policies and procedures for the following:

- Methodology for processing requests by providers for dental services for a member
- A description of the persons responsible for UM and their qualifications
- A written description of timeframes for non-urgent request, urgent request, notification to providers and enrollees of Plan's determination regarding requests for approvals and denials, requests for payments to a specialist provider, and emergency care.
- A description of the lines of authority and responsibility, personnel and committees related to utilization management

The Plan also has not demonstrated evidence that the UM program has been reviewed and approved by the governing board**.**

Corrective Action:

The Plan shall submit a corrective action that demonstrates the development and implementation of

written policies and procedures describing the UM process, including lines of authority and responsibility, personnel and committees related to the utilization department, a description of the persons responsible for utilization management and their qualifications. Also, the Plan shall provide evidence that the UM program has been reviewed and approved by the governing board.

Plan's Compliance Effort:

The Plan submitted policies and procedures for their UM process. Included was a description of the lines of authority and responsibility, personnel and committees related to the UM department. The Plan also submitted policies and procedure for "Specialist Referrals and Second Opinions", including Subscriber and Provider information on how the appeal/grievance system will be utilized when issues of a contested referral/claim arises.

Department's Finding Concerning Plan's compliance Effort:

Status: Uncorrected

Department's Comment:

The Plan has taken steps to remedy the deficiency as requested. However, The Plan was unable to demonstrate full compliance within the 45 day response. The Department's review of the Plan's corrective action indicates that the Plan has initiated a process/mechanism for Utilization Management. At the time of the Follow-Up Review, the Department will evaluate the current status of the corrected deficiency.

Appendix A

Interview List

The following are the title of key Plan officers and staff who were interviewed during the on site survey at the Plan's administrative offices on July 10 – 12, 2002.

Amir Neshat, D.D.S. - President/CEO

Arash Aghakhani, D.D.S. MS – Chief Dental Officer

Richard Herrera – Director of Operations

Anabel Collins – Member Services and Grievance Manager

Machelle Madden – Provider Relations Manager

Appendix B

DMHC Surveyor

Wendy Jang, R.D.H. Associate Health Plan Analyst (Survey Lead)

Appendix C

Acronyms

CEO – Chief Executive Officer

DMHC – Department of Managed Health Care

EOC– Evidence of Coverage

HMO – Health Maintence Organization

IS – Information System

PCD – Primary Care Dentist

QA – Quality Assurance

UM – Utilization Management